

  
Do not staple  
in this area.



**Uniform  
Medical Plan**

Your health. Your plan. Your choice.

# Claim Form

## Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient's name, date of service, diagnosis, and charge.
3. Retirees covered by Medicare who do not have an itemized bill need only attach a copy of the Explanation of Medicare Benefits (EOMB) form. Be sure to complete Section 3 of this form to avoid claims delay.
4. If services were rendered by a Uniform Medical Plan network provider and if the Uniform Medical Plan is the primary plan (meaning it pays before any other plan), you need not file a claim.
5. Mail your completed claim to: **Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850.**
6. Do not use this form for prescription drug or dental claims.

**Questions?** Employees: 1-800-762-6004; (425) 670-3000 Seattle  
Retirees: 1-800-352-3968; (425) 670-3150 Seattle

## Section 1 – Subscriber Information

A. Uniform Medical Plan Identification No.

B. Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Name First Name M.I. Mo. Day Yr.

C. Subscriber Home Address \_\_\_\_\_  
Street Address  
City State ZIP Code + 4 Work Phone Number Home Phone Number

D. Has your address changed since your last claim? ☐ Yes ☐ No

## Section 2 – Patient Information *Do not complete if patient is subscriber. Go to Section 3.*

A. Patient Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Name First Name M.I. Mo. Day Yr.

B. Relationship to subscriber  
☐ Spouse ☐ Other Specify: \_\_\_\_\_  
☐ Dependent stepchild  
☐ Dependent child under age 20

C. Is patient employed? ☐ Yes, full-time ☐ Yes, part-time ☐ No  
If yes: \_\_\_\_\_  
Name of Employer  
City State ZIP Code + 4 Employer's Phone Number

## Section 3 – Provider Information

**Complete this section if the provider information is not included on the bill.**

_____ Provider Name	_____ Provider Name
_____ Specialty	_____ Specialty
_____ Address	_____ Address
_____ City State ZIP Code + 4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	_____ City State ZIP Code + 4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Tax ID Number (if known)	Tax ID Number (if known)

## Section 4 – Accident or Work-Related Injury Information

A. Is this claim the result of a work-related illness or injury? ☐ Yes ☐ No

B. Is this claim due to any accident or injury? ☐ Yes ☐ No

**If you answered no to both questions, go to Section 5.**

C. Was illness or injury due to ☐ Auto Accident ☐ Other Specify: \_\_\_\_\_

D. Date accident occurred \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Yr.

E. Was a police report filed? ☐ Yes ☐ No **If yes, you must submit a copy of the police report with this claim.**

F. If auto accident, was patient wearing a seatbelt? ☐ Yes ☐ No

If motorcycle or bicycle accident, was patient wearing a helmet? ☐ Yes ☐ No

G. Explain where and how the illness or injury occurred \_\_\_\_\_  
\_\_\_\_\_

H. Auto or home owner's insurance company \_\_\_\_\_  
Name of Insurer

Street Address City State ZIP Code + 4 Phone Number

I. Insurance company of any third party involved with this loss \_\_\_\_\_  
Name of Insurer

Street Address City State ZIP Code + 4 Phone Number

J. Do you intend to seek repayment of medical expenses and/or work time lost for you or your dependent?

☐ Yes ☐ No Uncertain at this time

K. Will you file for any disability benefits? ☐ Yes ☐ No Uncertain at this time

L. Will you contact an attorney in this matter? ☐ Yes ☐ No Uncertain at this time

M. If yes: \_\_\_\_\_  
Name of Attorney Street Address City State ZIP Code + 4 Phone Number

## Section 5 – Other Coverage

A. Are patient's medical expenses covered by another employer's group health insurance, welfare, or government plan? ☐ Yes ☐ No

**If yes, and the other plan is primary, a copy of the Explanation of Benefits from the other plan must be attached.**

If yes, name of subscriber carrying other group coverage \_\_\_\_\_  
Name

Street Address City State ZIP Code + 4

Name of Plan Group Number

B. Is patient covered by Medicare? ☐ Yes ☐ No

**If no, go to Section 6. If yes, is a copy of the Explanation of Medicare Benefits enclosed?**

C. What type of Medicare coverage does patient have? ☐ Part A (Hospital) ☐ Part B (Physician)

D. Is Medicare coverage due to kidney disease? ☐ Yes ☐ No

E. Is Medicare coverage due to disability? ☐ Yes ☐ No

## Section 6 – Authorization to Pay

Have you paid for these charges? ☐ Yes ☐ No **Network providers are paid directly.**

**I certify this information is correct and authorize its release as required for administration of this claim.**

Please note that pursuant to Chapter 70.02 RCW, personal information that you may be required to submit to the Uniform Medical Plan, including medical records, cannot be disclosed without your express written consent. Other information is subject to the Health Care Authority's Public Records and Privacy Protections policy and is available upon request by calling 360-923-2822 or online at [www.wa.gov/hca/ump](http://www.wa.gov/hca/ump).